Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

New Student Enrollment Forms Packet (9-20)

The following packet contains forms that must be completed, signed by parent/guardian and returned to the Crown Point Central School.
To expedite the enrollment of your child please include all information requested.
Please use this guide as a checklist for all information pertinent to your child.

General Information

___ Social Security Number -**Please bring to copy**
___ Birth Certificate-**Please bring to copy**
___ Custody or Court Orders-**Please bring to copy**
___ Release of Information Form
___ New Pupil Registration Form
___ Housing Questionnaire
___ Residency Questionnaire Form

(2) Proofs of Residency are required

___ Special Education Information
___ Personal Emergency Information Form
___ Student Racial & Ethnic Form
___ Internet Permission/Student Agreement/E-Mail Form
___ Walking Field Trip/Photo Release Permission Form
___ Home Language Survey
___ Parent Portal Information
___ Pesticide Application Notification
___ Transportation Request/ Address
___ Free and Reduced Lunch Application & Guideline

Health Information

___ Letter from Nurse
___ Health Services Provided
___ Health Service Recommendations
___ Immunization Record Guideline
___ School Entry Questionnaire
___ Health Survey
___ Health Examination Form
___ Hearing/Vision Questionnaires
___ Authorization for Treatment
___ Allergy Information Form
___ Student Medication Policy
___ Authorization Form For Administration of Medicine
___ Severe Food Allergy
___ Head Lice Information
___ Lead Screening Requirement
___ Health Insurance
___ BMI Authorization
___ Dental Health Certificate Optional
___ Medicaid Consent Form

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Release of Information

_____(_____)_____/___/____
Student Name: Last, First, Middle Grade Level Date of Birth

The student above has transferred to Crown Point Central School and indicated that he/she attended your school. Please send all of the following information that applies to this student.

- Student Transcript/Report Cards
- Health Immunization Records
- Disciplinary Referrals / Actions
- Standardized Test Scores
- Psychological Reports, IEP or 504 Plans
- All lab reports done for Regents Science Classes
- If you use **IEP Direct**, please transfer student's special education documents to us electronically.
  Att: Tieah Gunnison, CPSE Chairperson

For State Data Warehouse purposes, the end date of enrollment for this student in your school district is _____.
(Month / Day/ Year)

_____
Signature of Parent / Guardian / Other Date

E-mail to mainoffice@cpcsteam.org
OR Mail / FAX Records to
Student Enrollment
Crown Point Central School
PO Box 35, 2758 Main Street
Crown Point, New York 12928

Parent Permission is no longer required when authorized school personnel request records. (Family Educational Rights and Privacy Act, final Rule on Educational Records, Federal Register, June 17, 1976, vol. 41, no. 118, pg. 24673)

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

New Pupil Registration

_____ _____
Student's Name - Last, Frist, and Middle S.S. Number
M/F
____/____/_____ _____ _____
Date of Birth Place of Birth Grade

_____
Town

_____
State, Zip

_____
Name of Last School Attended

_____
Address

_____
Town, State, Zip

_____
Phone, FAX Number

Parent/Guardian Information (If separated or divorced, provide custody documentation and any court ordered child contact restrictions

_____ _____
Father's Name Highest Education Level

_____
Street Address

_____
Town, State, Zip

_____
Phone: Home Cell Work

_____
Student Siblings (Name/Age/Address)

_____
Student Siblings (Name/Address)

_____ _____
Mother's Name Highest Education Level

_____
Street Address

_____
Town, State, Zip

_____
Phone: Home Cell Work

_____
Student Siblings (Name/Age/Address)

_____
Student Siblings (Name/Address)

Other Information (Please update us with any changes regarding this information)

_____
Emergency Contact-Name & Daytime Phone Number

_____
Emergency contact – Name & Daytime Phone Number

_____
Family Physician Name & Phone Number _____

What grade, if any has your child repeated_____ Does the student have an IEP or 504 plan_____

Does the student receive AIS or any extra help? _____

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: _____ /_____ /_____ Grade: _____ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

_____ _____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

If **ANY box other than "In Permanent Housing" is checked.**, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled. After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

Rev. 11/15/16

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Residency Questionnaire

Name of Student: _____ Male: _____ Female_____
Last, First, Middle

Address _____ZIP_____

Birth Date _____/___/_____Grade_____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services that student may be eligible to receive. Students who are protected under the McKinney-Vento act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

1. Is your current address a temporary living arrangement?
   _____Yes _____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship?
   _____Yes _____No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living? (Check one box.)

- o In a motel
- o In a shelter
- o With more than one family in a house or apartment.
- o Moving from place to place.
- o In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite.

Name of parent(s)/Legal Guardian(s) _____

Phone: _____
Home Cell Work

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs.

_____
Signature of Parent/Legal Guardian Date

I certify the above-named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Information about Special Education upon entry to school
Chapter 434 of the Laws of 2014

Statute: Section 4402
Effective Date: July 1, 2015

Dear Parent/Guardian:

School districts are now required to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of Special Education services or programs upon their entry into public school. Please find the statute below. A parent's guide to special Education can be found on the New York State Education department's website at WWW.NYSED.GOV. This guide is available in both English and Spanish.

Statute; Chapter 434 of the Laws of 2014

Section 1. Section 4402 of the Education Law is amended by adding a new *Subdivision 8* to read as follows:

Subdivision 8. Upon their child's enrollment or attendance in a public school, such school shall notify every parent or person in parental relation of their rights regarding referral and evaluation of their child for the purposes of Special Education services or programs pursuant to applicable federal and state laws. Such notification may be provided by directing parents or persons in parental relation to obtain information located on the department's website relating to *A Parent's Guide to Special Education* in New York for children ages three through twenty-one provided the notification shall also contain the name and contact information for the chairperson of the school district's committee on Special Education or other individual who is charged with processing referrals to the Committee in the district.

Section 2. This act shall take effect July 1, 2015. Effective immediately, the addition, amendment and/or repeal of any rules or regulations necessary for the implementation of this act on its effective date are authorized to be made on or before such date,

If you have any questions, please contact our

CSE Chairperson, Tieah Gunnison
@ tgunnison@cpcsteam.org
or 518-597-3285

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Emergency Contact / Medical Information

Student's Name | Grade | Date of Birth

Physical Address | Mailing Address

City, State, Zip Code

Parent/Guardian's Name (Primary) | Relationship

Home Phone | Work Phone | Cell Phone | E-Mail Address

Parent/Guardian's Name | Relationship

Home Phone | Work Phone | Cell Phone | E-Mail Address

Alternative Emergency Contacts

Primary Emergency Contact | Home Phone | Cell Phone | Work Phone

Secondary Emergency contact | Home Phone | Cell Phone | Work Phone

Medical Information

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Physician's Name | Phone

Allergies/Special Health Considerations- (Please be specific)

Parent/Guardian's Signature | Date

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Student Racial and Ethnic Identification

To Parent(s)/ Guardians:

The Crown Point Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Crown Point Central School District in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check in the box for the category or categories which best describe your child. The Crown Point Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Confidentiality Procedures and Regulations

To School Staff:

This form will be filed in the student's permanent record as confidential information.

To Parent(s)/Guardian:

The information which you have provided on this form is confidential. It is protected by the confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

Please complete the form on the back

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Student Racial and Ethnicity Identification Form

Student Name: _____ Date of Birth: _____

Please answer questions (1) & (2). **PLEASE READ THEM BEFORE YOU RESPOND.**

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, of Spanish origin, means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin.

	YES- Hispanic
	NO- Not Hispanic

For question (2) mark an X in the box that best describes your child.

2. Select one or more races from the following five racial groups. Mark an X in all groups that apply to your child; Mark at least (ONE) box.

	WHITE - A person having origins in any of the original peoples of Europe, including Spain, North Africa, or the Middle East.
	BLACK - A person having origins in any of the black racial groups of Africa
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER –A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.
	ASIAN- A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands. Thailand, and Vietnam.
	NATIVE AMERICAN INDIAN OR NATIVE ALASKAN- a PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEROPLES OF North and South America (including Central America), and who derives tribal affiliation or attachment. For example, Cherokee, Mohawk, Inuit, Mayan, Inca (but not limited to those listed).

_____

Signature of Parent / Guardian/Other Date

Relationship to Student (Please check one box below)

Mother Father Guardian Other (Specify) _____

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Caleb Spaulding- Transportation Supervisor
518-597-4208

Transportation Request

Name of Student _____
Last First, Middle

Street Address: _____

Town, State, Zip _____

Phone: _____
Home Work Cell

_____ _____
Print / Parent or Guardian Signature / Parent/Guardian

Additional Information: _____

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Walking Field Trip Permission Slip

By signing this permission slip, your child can accompany the class on such trips and a separate permission slip will not be necessary each time.

My child, _____, has my permission to participate in any field trips that occur within walking distance of the Crown Point Central School.

Parent/Guardian _____Date: _____

Press Release / Photography Release Form

Dear Parent / Guardian:
Please read the photo consent below, circle "yes" or "no", sign and date the form.

Yes No I give permission for my child's photo to be used on the Crown Point Central School website for educational accomplishments and work.

Yes No I give permission for my child's photo to be used in written materials, such as school newsletters or local newspapers for educational accomplishments and work.

Parent/Guardian_____Date:_____

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Internet Permission Slip

If you wish to allow your child access to the district's computer network and the internet, please sign and return this form. Failure to return this form will result in your child being denied access to the Crown Point School Network and Internet.

As the parent of legal guardian of _____,
I grant my son or daughter to access networked computer services such as Internet. I understand that individuals and families may be held liable for violations. I understand that some materials on the Internet may be objectionable, but I accept responsibility for guidance of Internet use-setting and conveying standards for my daughter or son to follow when selecting, sharing, or exploring information and media.

_____

Parent / Guardian Signature Date

Student Agreement Form

As a user of the Crown Point Central School computer network, I hereby agree to comply with the above stated rules, communicating over the network in a reliable fashion, while honoring all relevant laws and restrictions. I understand that some materials on the Internet may be objectionable and are inappropriate and unacceptable for use in a school environment. I accept responsibility for Internet use when selecting, sharing or exploring information and media.

_____

Student Signature Date

E-Mail Permission Form

I give my child _____, permission to have a school-based e-mail based upon the Student E-Mail System Policy on page 70 & 71 in the Student Handbook.

_____

Parent / Guardian Signature Date

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Home Language Survey

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these quew5ions is greatly appreciated.
Thank you

Crown Point Central School District

Student Name – *Date of Birth*

Student ID Number *Grade*

Country of Birth / Ancestry

Number of years enrolled in school outside the US

Determination O *Possible LEP*
O *English Proficient*

1. What language(s) is spoken in the student's home or residence?
   O English O Other _____
2. What language(s) are spoken most of the time to the student, in home or residence?
   O English O Other _____
3. What language(s) does the student understand?
   O English O Other _____
4. What language(s) does the student speak?
5. O English O Other _____
6. What language(s) does the student read?
7. O English O Other _____
8. What language(s) does the student write?
9. O English O Other _____
10. In your opinion, how well does the student understand, speak, read and write English?

	Very Well	Only a little	Not at all
Understands English	O	O	O
Speaks English	O	O	O
Reads English	O	O	O
Writes English	O	O	O

Signature of Parent / Guardian / Other Date

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Parent Portal
Monitor Your Child's Academic Progress Online

Dear parents or Guardians:

Our school uses *SchoolTool,* a student management system for report cards, attendance, discipline, etc. The *SchoolTool* Parent Portal is one of the many ways to keep in touch with your child's academic progress. It is available to all parents in the Crown Point Central School District for students in grades 6-12. The Parent Portal is a component of the *SchoolTool* student information system and allows parents and/or legal guardians to view their child's class schedule, grades, assignments, attendance record, and discipline history and contact information from any device that can access the internet.

If you are interested in using the parent portal, please go online to cpcsteam.org and complete the online registration form located under the Parent Portal Tab. Once the form is submitted to the office you will receive an email with information about logging in and creating an account as well as some basic information about how to use the portal and find information.

On the back of this letter is information about what to do once you have received a username and password

If you submit the registration form, please keep this letter to guide you through the portal.

Please contact the school office with any questions.

Lori Cutting
School Secretary

→

SchoolTool- what you will see/how to use

From the Crown Point Central School Home page- cpcsteam.org
Tab over to Parents
Click on Parent Portal Request Form
Complete Form and hit Send
You will receive a password.

After you log-in

You will see your child's name/address.
Click on the purple triangle to the left of your child's name.

Under your child's contact information

In green you will see what class your child is in at the current time, if you are checking between 8AM and 2:25PM.

Below your child's contact information are tabs for Contacts, Schedule, Attendance, Discipline, Grades, Assessments, Assignments and Letters.

- CONTACTS- shows you all of the contact information that you provided to the school.
- SCHEDULE- shows your child's schedule. Next to the teacher's name is an email icon you can click on to email that teacher.
- ATTENDANCE- shows your child's attendance by day or by class.
- DISCIPLINE- shows any discipline reports on your child.
- GRADES-shows your child's grades. The view drop down box allows you to see the marking period grades, progress report grades or the marking period averages.
- ASSESSMENTS- shows your child's state test scores on the 3-8 math and ELA exams.
- ASSIGNMENTS- shows your child's assignments and grades that have been entered into each teacher's grade book.
- LETTERS- shows any letters that have been sent home regarding your child.

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Dear Parents, Guardians and School Staff;

NYS Education law Section 409-H, effective July 1, 2001, requires all public and non-public elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year.

The following pesticide application(s) took place:

Date of Application	Location of Application	Product Used
NONE		

As a reminder, Crown Point Central School is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are not subject to prior notification requirement.

- The school remains unoccupied for a continuous 72 hours following the application of a pesticide that would otherwise dictate the use of a 48-hour notification.
- Anti-microbial products; non-volatile rodenticides in tamper-resistant bait stations in areas inaccessible to children.
- Non-volatile insecticidal baits in tamper-resistant bail stations in areas inaccessible to children.
- Silica gels and other non-volatile, ready-to use pastes, foams, or gels in areas in accessible to children.
- Boric acid and disodium octaborate tetra hydrate.
- The application of EPA designated exempt materials under 40CFR152.25.
- The use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

In the event of an emergency application necessary to protect against an imminent threat to human health, God Faith effort will be made to supply written notification to those on the 48-hour Prior Notification List. If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in our school buildings, please complete the enclosed form and return it to Caleb Spaulding, IPM coordinator, Crown Point Central School, PO Box 35, Crown Point, NY 12928

Please feel free to contact me at 518-597-3285 for further information on these requirements.

Sincerely,

Caleb Spaulding, CPCS IPM Coordinator

CS/lmc
Cc;Tara S. Celotti, Superintendent of Schools

Crown Point Central School
P.O. Box 35, 2758 Main Street
Crown Point, NY 12928
518-597-4200/3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Request for Pesticide Application Notification

Please Print

_____
(Name)

_____
(Address)

_____
(Town, State, Zip code)

_____
(Day Phone)

_____
(Evening Phone)

_____
(E-mail Address)

Date Withdrew_____ F____R____D____

2022-2023 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call ***(phone number)***, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **(School Name)**
(Street Name)
(City, State, Zip Code)

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX-__ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#) or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.
Signature: _____ **Date:** _____
Email Address: _____
Home Phone: _____ Work Phone: _____ Home Address: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official_____ **Date Notice Sent:** _____

FREE AND REDUCED PRICE MEAL APPLICATION FACT SHEET

When filling out the application form, please pay careful attention to these helpful hints.

SNAP/TANF/FDPIR case number: This must be the complete valid case number supplied to you by the agency including all numbers and letters, for example, E123456, or whatever combination is used in your county. Refer to a letter you received from your local Department of Social Services for your case number or contact them for your number.

Foster Child: A child who is living with a family but who is under the legal care of the welfare agency or court may be listed on your family application. List the child's "personal use" income. This includes only those funds provided by the agency which are identified for the personal use of the child, such as personal spending allowances, money received by his/her family, or from a job. Funds provided for housing, food and care, medical, and therapeutic needs are not considered income to the foster child. Write "0" if the child has no personal use income.

Household: A group of related or non-related people who are living in one house and share income and expenses.

Adult Family Members: All related and non-related people who are 21 years of age and older living in your house.

Financially Independent: A person is financially independent and a separate economic unit/household when his or her earnings and expenses are not shared by the family/household. Separate economic units in the same residence are characterized by prorating expenses and by economic independence from one another.

Current Gross Income: Money earned or received at the present time by each member of your household before deductions. Examples of deductions are federal tax, State tax, and Social Security deductions. If you have more than one job, you must list the income from all jobs. If you receive income from more than one source (wage, alimony, child support, etc.), you must list the income from all sources. Only farmers, self-employed workers, migrant workers, and other seasonal employees may use their income for the past 12 months reported from their 1040 Tax Forms.

Examples of gross income are:

- Wages, salaries, tips, commissions, or income from self-employment
- Net farm income – gross sales minus expenses only – not losses
- Pensions, annuities, or other retirement income including Social Security retirement benefits
- Unemployment compensation
- Welfare payments (does not include value of SNAP)
- Public Assistance payments
- Adoption assistance
- Supplemental Security Income (SSI) or Social Security Survivor's Benefits
- Alimony or child support payments
- Disability benefits, including workman's compensation
- Veteran's subsistence benefits
- Interest or dividend income
- Cash withdrawn from savings, investments, trusts, and other resources which would be available to pay for a child's meals
- Other cash income

Income Exclusions: The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care Development (Block Grant) Fund should not be considered as income for this program.

If you have any questions or need help in filling out the application form, please contact:

Name: _____ Title: _____

Telephone Number: _____

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to _____. If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: _____. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.
We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Dear Parents/Guardians

In this health packet you will find 5 enclosures to be completed prior to the first day at school. Physical exam form, school entry questionnaire, health survey, hearing screening questionnaire, vision problem questionnaire, authorization for treatment, allergy form, and if needed a medication form. You will also be required to bring your child's immunization record, which will be copied and be part of their school health file. Enclosed is a New York State Immunization requirement for school entrance/attendance. Students failing to meet these requirements will not be permitted to start school until completely immunized.

New York State Education Law and Regulations require physical examinations of children when they enter the school district for the first time. (Includes Pre-Kindergarten and new students of any grade level.) Such examination shall be acceptable for purposes of this section if it is administered not more than twelve months prior to the commencement of the school year in which the examination is required.

All documentation is reviewed upon arrival the first day of school. Complete all forms in advance. Please feel free to call if you have any questions. We look forward to a great school year.

If you have any further questions please contact me at 518-597-3285.

Thank You,

Kellie Bilow BSN, RN
School Nurse

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Health Services Provided

I would like to take this opportunity to explain the school health services provided here at Crown Point Central School, and New York State Regulations. The Personal Emergency Form you filled out in the enrollment papers is a very important document for your child. If your child has special needs, please inform the school nurse. Examples of such are asthma, bee sting allergies, food allergies, or a need for medication in school.

PERSONAL EMERGENCY FORM: More and more parents are away from home during the day and it is essential for protection of our students to be able to reach someone in case an emergency arises. Please list all contact numbers for yourselves, and consider the availability of the contact persons you are listing.

HEAD LICE: Screenings randomly done throughout the year. Most common in the spring and the fall season, can easily be treated with special over the counter products. Crown Point Central School has a no nit policy. No student will be allowed in school until cleared by the school nurse. Please note the enclosure on head lice.

ACCIDENTS IN SCHOOL: If a student is injured in school, the parent is notified. The student will be treated with appropriate first aid measures until the person in parental authority can authorize further treatment. Crown Point Central School maintains a student accident insurance policy that is non-duplicating. If an accident occurs during school or a school sponsored activity, this policy will pay claims in excess of any other coverage you may have on your child, up to the usual and reasonable expenses as determined by the insurance carrier.

IMMUNIZATIONS: All students in New York State are required to be properly immunized for school entrance and attendance. Information enclosed.

See back →

SCHOOL PHYSICALS: School physicals are required yearly on grades K,2,4,7,10 and on all new students before entering school. Sports physicals, physicals for participation in school sports may be scheduled at any time during the calendar year. The physical is valid for a period of 12 months.

DISTANCE VISION SCREENING: Is completed yearly on students in Pre-K, K, 1,2,3,5,7 and 10th grade. The purpose of a school vision screening program is to identify students with visual impairments. Visual problems can and o affect the physical, intellectual, social and emotional development of children. Early detection of vision problems will provide a child more opportunity for educational success.

HEARING SCREENING: Must be administered to all students within 6 months of admission to the school and in Pre-K, K, 1,3,5,7 and 10th grade.

Crown Point Central School

"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285 ext. 4
kellie.bilow@cpcsteam.org

Dear Parent/Guardian:

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings will be required or completed at school:

Vision

- Distance acuity for all newly entering students and students in Kindergarten, Grades 1, 2, 3, 5, 7 and 10.
- Near vision acuity and color perception screening for all newly entering students.

Hearing

- Hearing screening for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7 and 10.

Scoliosis

- Scoliosis (spinal curvature) screening for all students in Grades 5 – 9.

Health Appraisals

- A physical examination including Body Mass Index and Weight Status Category Information is required for all newly entering students and students in Pre-Kindergarten **or** Kindergarten, Grades 2, 4, 7 and 10.

Dental Certificates

- A dental certificate is requested for all newly entering students and students in Kindergarten, Grades 2, 4, 7 and 10.

A letter will be sent home if there are any findings on the screening done at school that would cause concern or need medical follow-up. Please call the school's Health Office if you have any questions or concerns.

School Nurse: Kellie Bilow BSN, RN		School: Crown Point Central School
Phone: 518-597-3285	Fax: 518-597-4121	Email: kellie.bilow@cpcsteam.org

2020-21 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]		**Not applicable**	**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses** or **2 doses of adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**	**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grade 6: 10 years; minimum age for grades 7 through 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 through 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. Only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

School Entry Questionnaire

No one knows a child better than their parents or guardian. Please answer the questions below so we may gain more insight concerning your child.

Student Name: _____ Birthdate: _____

Address: _____

Name of Pre-School _____ Dates Attended: _____

Father's Name: _____

Address: _____

Phone Number: _____
Home Cell Work

Occupation: _____ Work Location: _____

Education: Circle highest grade he completed: Grade 9, 10, 11, 12, College: 1, 2, 3, 4

Mother's Name: _____

Address: _____

Phone Number: _____
Home Cell Work

Occupation: _____ Work Location: _____

Education: Circle highest grade he completed: Grade 9, 10, 11, 12, College: 1, 2, 3, 4

Parent's Marital Status:

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

If parents are separated or divorced, Parent with legal custody is _____

(Continued on back) ------

→

Siblings:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Do you have any legal documents for us to follow? _____ Please provide to copy.

Is there anyone forbidden to see or pickup your child? _____

Who is directly responsible for your child if the parents work?

_____

Name & telephone number of person to notify in case of emergency, if neither parent can be reached. _____

In case of an emergency, do you authorize the school officials to use their best judgement in aiding your child? _____Yes _____ No

Has your child ever had a seizure? _____ Yes _____ No

Information: _____

How does your child feel about starting school? _____

Is your child easily disciplined (does he/she accept direction)? _____Yes _____No

How do you discipline? _____

Is it effective? _____Yes _____No

In your opinion, does your child need help in any specific area? (Speech, social relationships, small or large muscle coordination, etc.) Please comment.

_____

_____

_____

_____

Additional information you wish to share.

_____

_____

_____

_____

_____

_____

_____


Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Health Survey

Student's Name: _____ Sex: _____ DOB: _____

Family Doctor: _____ Phone Number: _____

Address: _____ Date of Last Exam: _____

Has your child had: (Please give dates and pertinent information.)

_____ Repeated Illnesses: _____

_____ Serious Injuries: _____

_____ Surgery/Hospitalization: _____

_____ Chicken Pox (Must have documentation from Health Care Provider with date of disease).

Does your child have: (Please give dates and pertinent information.)

_____ Any Allergies: _____

_____ Vision Problems: _____

_____ Wear Glasses _____

_____ Hearing Problems: _____

Will he/she need to take medication during school hours? _____

(If yes, please see the School Nurse for the required physician's order form.)

Please comment on any health concern not mentioned above that you would like your child's teacher and school nurse to be aware of.

_____

_____

_

CROWN POINT CENTRAL SCHOOL
P.O. BOX 35
2758 MAIN STREET
CROWN POINT, IN 46307

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

CROWN POINT CENTRAL SCHOOL

Name: P.O. BOX 35 2758 MAIN STREET CROWN POINT, NY 12928				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Hearing Screening Questionnaire

Student's Name: _____ Sex: _____ DOB: _____

1. How many colds/sore throats does your child have every year? _____
2. Has your child had more than ear infections in the past year? _____
3. Do any of his/her siblings have an ear problem? _____
4. Did parents/grandparents have hearing problems as children? _____
5. Does your child respond to or communicate with people outside the family? _____
6. Does your child watch your mouth when you speak to him/her? _____
7. Does your child stand very close to the TV or to speak to you? _____
8. Does your child have trouble paying attention when you speak? _____
9. Does your child respond when you call him/her from another room? _____
10. Does your child sneeze a lot or have a stuffy nose frequently? _____
11. Does your child have discharge from his/her ears or a problem with earwax? _____
12. How do you clean your child's ears? _____
13. Do you talk to your child about not putting things in his/her ears? _____
14. How do you cleanse ear lobes after ears are pierced? _____
15. Is there any history of allergy in your family? _____
16. Does your child have an allergy to foods, medicines, pollens, animals or anything else?
    _____
17. Is there cigarette smoking in your house? _____
18. Any other pertinent information not mentioned above that you would like your child's teacher and school nurse to be aware of? If so, list below.

_____
_____
_____
_____
_____
_____

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Vision Questionnaire

Student's Name: _____ Sex: _____ DOB: _____

1. Hold a book very close (7-8 inches away)? _____
2. Turning head to use only one eye? _____
3. Cover or close one eye while reading? _____
4. Squint for either near or far vision tasks? _____
5. Move head back and forth, rather than eyes while reading? _____
6. Omit letters, words or phrases? _____
7. Complain of seeing double or blurred vision? _____
8. Hand writing which is difficult to read, crowded or inconsistent in size?_____
9. Mistakes words with similar beginnings? _____
10. Miscalls or omits small words? _____
11. Excessive blinking or watering of eyes? _____
12. Loses place while reading? _____
13. Headaches during or after reading? _____
14. Misaligns digits in columns of numbers? _____
15. Writes uphill or downhill? _____
16. Reverses letters (d for b) or words (saw for was)? _____
17. Uses a finger or marker to keep place? _____
18. Re-reading or skips words while reading? _____
19. Excessive rubbing of eyes while engaged in visual tasks? _____
20. Fatigues easily? _____
21. Lip reads or whisper reading to reinforce comprehension? _____
22. Poor eye-hand coordination (difficulty catching a ball)? _____
23. Burning or itching eyes? _____
24. Any other pertinent information not mentioned above that you would like Your child's teacher and school nurse to be aware of? If so, list below.

_____

_____

Crown Point Central School

"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Authorization for Administration or Treatment

I request that my child, _____ DOB _____ Grade _____
Receive the following checked items of over the counter medications for injuries, sickness, itching, burns, upset stomach, couth, dry lips, and tooth pain.

Parent/Guardian Signature Date

Address

Home Phone Cell Phone Work Phone

_____ Sugarless cough drops/Sore throat drops
_____ Saline solution for eyes/contact lens
_____ Dacriose: sterile eye irrigation solution
_____ Visine: eye drops
_____ Hand lotion: chapped/dry hands
_____ Blistex lip ointment: cold sore, chapped lip
_____ Ora-Jel Mouth aid: toothache, canker, cold sore
_____ Anbesol: mouth pain
_____ Vaseline: chapped lips
_____ Bacitracin ointment: first aid, prevent infection
_____ Betadine: cleans scrapes and wounds
_____ Caladryl: relieves itching from but bites, poison ivy
_____ Calamine lotion: relief of itching
_____ Hydrocortisone cream, 1%: anti itch
_____ Foot powder: treats athletes foot, itching & burning
_____ Rubbing alcohol: cleansing newly pierced ears
_____ Calcium antacid chewable tablets: upset stomach
_____ Pepto-Bismol: upset stomach reliever/antidiarrheal
_____ Assorted band aids, bandage, tape, gauze dressings.

Tylenol and Advil must have a physician's prescription and a signed school medication authorization form signed by both physician and parent/guardian.

Crown Point Central School

"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
Kellie.bilow@cpcsteam.org

Allergy Information

Dear Parent/Guardian;

It is important to know if your child has any allergy problems. Please be specific.

My child, _____ is/is not (circle one) allergic to bee stings.

My child has a local reaction only (at site if stung) and requires treatment as follows:

Benadryl cannot be administered without a physician's order

_____

_____

_____

Medication Allergies: Please list

_____

_____

_____

Food Allergies: Please List

_____

_____

Any medication needed to treat any allergy needs to be in the health office in accordance with the New York State Dept. of Health/Education Law.

- **Written parental permission to give specified medication.**
- **Doctor's written authorization to give specified medication.**
- **Medication in its original container or package with prescription attached and delivered to the school nurse by a responsible adult.**

_____

Parent / Guardian Date

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Medication Policy

The administration of any medication to a student during school hours will be permitted ONLY when failure to take such medication would jeopardize the health of a student. Medication will include all prescribed medication by a physician and includes over the counter medications such as Aspirin, Tylenol, cough Syrup, etc.

BEFORE ANY MEDICATION MAY BE ADMINISTERED TO A STUDENT during school hours the New York State Department of Education and Health and the Crown Point Central School Board require:

- **The written consent of the parent and the physician, which will give permission for administration of medication and relieves the board and its employees of liability**
- **The written consent of the physician, describing dosage, appropriate time to medicate, possible side effects, diagnosis, etc.**
- **The medication has to be in its original container showing the original prescription with the pharmacist's label attached.**

Procedures for administering medications will require

1. All medications will be brought to school by the parent/guardian or a designee appointed by the parent and personally given directly to the school nurse. The nurse will count the medication with the parent/designee and record.
2. All medications will be administered by the school nurse, the principal or his/her designee.
3. Medications will be securely stored and kept in their original labeled container, locked in the nurse's office.
4. The school nurse will maintain a record of the name of the student to whom medication is to be administered, the prescribing physician, the dosage, time of administration and initialed by the nurse at each scheduled time.
5. All medications should be picked up at the end of the school year or at the end of the medication regime, whichever comes first. ALL MEDICATIONS NOT PICKED UP WITHIN FIVE (5) DAYS AFTER END OF MEDICATION PERIOD OR CLOSE OF SCHOOL WILL BE DISCARDED.

Crown Point Central School

"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Authorization for Administration of Medication in School

I request that my child _____ Grade _____
Receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the original labeled container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

_____
Parent/Guardian

_____
Address

_____
Home Phone Cell Phone Work Phone

To be completed by the Licensed Health Care Provider

I request that my patient listed below, receive the following medication:

_____
Name of Student DOB

_____
Diagnosis:

_____
Name of Medication Times to be administered

_____
Duration of Treatment

_____
Possible Side Effects and adverse reactions (if any)

_____
Other recommendations

_____
Name of Licensed Physician and Title (Please Print)

_____
Physician's Signature Date

_____
Address

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

SEVERE ALLERGY ALERT

We are committed to providing a safe and welcoming environment for all of the children in our school.

THERE IS AT LEAST ONE CHILD IN CROWN POINT CENTRAL SCHOOL THAT HAS A

SEVERE FOOD ALLERGY (5-12-2021)

The food(s) that we are concerned with are:
PEANUTS, ALL NUTS, WHITE POTATO, MILK, EGG, COCONUT, AVACADO, OAT, WHOLE WHEAT, MUSHROOMS, ALL FISH, TUNA, PINEAPPLE, ONIONS, & ORANGES

While some allergic reactions can be mild, many students with severe food allergies experience serious, potentially life-threatening symptoms to eating (and in some cases touching and smelling) the food that they are allergic to. Please be careful not to send foods into the school that contain things that students may be allergic to.

Specific classroom with children with food allergies will receive additional information as to foods permitted and protocols to be followed.

In addition, there are designated areas in the building that will be designated as allergen free.

Please call the school's Health Office if you have any questions or concerns.

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Head Lice (Pediculus Humanus Capitis)

Students are screened for Head Lice throughout the school year by the school nurse. If a student is observed to be scratching his/her head, he/she will be sent to the nurse for evaluation.

When Head Lice or Nits are found the parents are called and the student has to go home for treatment and will not be allowed to return to school until he/she is

NIT-FREE. The student has to be evaluated by the school nurse prior to entering the classroom on return to school.

Crown Point Central School has a **NIT-FREE** Policy which means:

1. Removing all lice eggs (nits) and egg cases after treatment with a lice killing product.
2. Excluding a child with a lice infestation from school until ALL NITS HAVE BEEN EMOVED.
3. Educating the community to insure that parents understand their responsibility under the "NO-NIT policy.

The "NO-NIT" Policy encourages home screening, eliminates diagnostic confusion, prevents transmission and re-infestation, and reduces the need for subsequent treatment.

PROPER SCREENING TECHNIQUES

When screening children for nits do the screening in natural light – near a window or with a magnification lamp. Nits are good reflectors of Ultra Violet light.

Use disposable screening tools such as: wooden sticks, tongue depressors, toothpicks or cotton applicators – so that screening personnel do not have to touch the child's hair, gloves may be used.

Conduct a thorough search – lice eggs are normally laid on hair close to the scalp.

Crown Point Central School
"Home of the Panthers"

Health Department
Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcsteam.org

Lead Screening
(Required)

NYS PUBLIC HEALTH LAW ARTICLE 13, TITLE 10, SECTION 1370-1376a STATES THAT:

- Prior to or within (3) three months of initial enrollment, schools are required to obtain from the pre-school child's parent or guardian, proof that the child has had a blood lead test.
- If evidence of blood lead testing has not been received within the (3) three months of initial enrollment, the parent or guardian is :

    1. To be given information about lead poisoning; and

    2. To be referred to primary health care provider or local heal department.

- The child's cumulative health record must indicate either the date of the lead test screening or that information on lead poisoning referral was provided.

Though the requirements above must be completed, a student lacking proof of lead testing may not be excluded from school (unlike failure to comply with immunization requirements).

Does Your Child Need Health Insurance?

Dear Parent:

Fidelis Care wants every student to have quality, affordable health insurance coverage. That's why we've teamed up with your child's school to tell parents like you about the New York State-sponsored Child Health Plus program with Fidelis Care.

Coverage may be free or as little as $9 per child per month based on income and family size. There are no copays for care or services. And for families at the full premium level, Fidelis Care offers some of the lowest rates available!

Child Health Plus Benefits keep kids healthy and on the go:

- Well-child care and checkups
- Diagnosis and treatment of illness and injury
- Hospital inpatient and emergency care
- Immunizations
- X-rays and lab tests
- Speech and hearing care
- Prescription drugs
- Dental and vision care
- and much more!

Your child may be eligible for Child Health Plus if he or she is under the age of 19 and a resident of New York State.

Questions? Email Fidelis Care at psoutreach@fideliscare.org

You can also call 1-888-FIDELIS (1-888-343-3547) or apply for Child Health Plus with Fidelis Care through NY State of Health: The Official Health Plan Marketplace, at www.nystateofhealth.ny.gov.

Child Health Plus
New York State's Health Plan for Kids

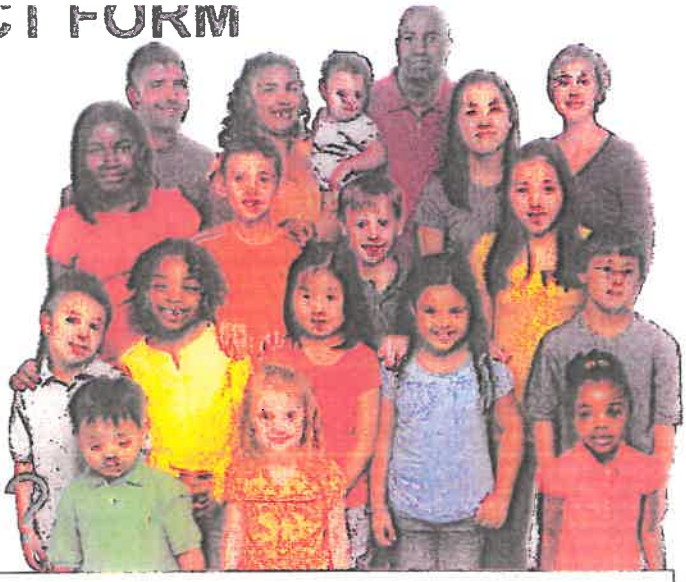
nystateofhealth
The Official Health Plan Marketplace

To learn more about applying for health insurance including Child Health Plus and Medicaid through NY State of Health, the Official Health Plan Marketplace, visit www.nystateofhealth.ny.gov or call 1-855-355-5777.

1-888-FIDELIS | fideliscare.org
(1-888-343-3547) • TTY: 1-800-421-1220

PERMISSION-TO-CONTACT FORM

FIDELIS CARE®



Do You Need Health Insurance?

___ **YES!** Please have a Fidelis Care representative contact me regarding free or low-cost health insurance coverage

___ **YES!** Please help me stay covered with Fidelis Care and contact me regarding questions about my recertification

Please fill out the form below and fax to Fidelis Care at **(518) 427-9584**, or mail to **31 British American Blvd., Latham, NY 12110.**

Name (please print):_____

Street: _____ City: _____ State: _____

Zip _____ County:_____ Home Phone: (___)_____

Cell Phone: (___)_____ Work Phone: (___)_____

Email address:_____ Member ID# (if already a member) _____

What is the best time to contact you: ___ Mornings ___Afternoons ___ Evenings

What is your primary language: _____

How did you hear about Fidelis Care? (Referral Source) _____

Signature: _____ Date: _____

By completing and signing this form, I give permission for a Fidelis Care representative to contact me regarding health insurance or to renew my current coverage.

For more information, call **1-888-FIDELIS (1-888-343-3547)**
(TTY: 1-800-421-1220) or visit fideliscare.org Updated June 2015

Crown Point Central School

"Home of the Panthers"
Health Department

Kellie Bilow BSN, RN
518-597-3285
kellie.bilow@cpcstem.org

BMI Authorization

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or "BMI". The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student's school health examination. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting to New York State Department of Health information about our student's weight status groups. Only summary information is went. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report.

The information sent to New York State Department of Health will help health officials develop programs that make it easier for children to be healthier.

If you do not wish to have your child's weight status group information included as part of the Health Department's survey this year, please print and sign your name below and return this form to:

- -

Crown Point Central School
Attention: School Nurse

Date: ____________________

Please do not include my child's weight status information in the Annual school Survey.

Child's Name:

____

Print Parent's Name: ____

Parent's Signature: ____

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: € Male € Female

Will this be your child's first oral health assessment ? € Yes € No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? € Yes € No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment)
The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address
(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

€ Yes € No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

€ Yes € No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

€ Yes € No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

€ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

€ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

€ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Crown Point Central School District
Committee on Special Education
2758 Main St.
PO Box 35
Crown Point, NY 12928 (518-597-3285 x6)

Medicaid Consent

Dear Parent or Guardian:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP).

This consent allows the school district to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of, _____
have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Client Identification Number (CIN): _____

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?

- ☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- ☐ Trabajando en la cultivación o procesamiento de los árboles.
- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.

Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____

Teléfono: (_____)-_____-_____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad_____ Grado_____

Nombre del estudiante: _____ Edad_____ Grado_____

Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a
NYS Migrant Education Program- Identification & Recruitment Office
100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020